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Express Scripts Provider Certification

GENERAL INFORMATION:

NCPDP:	5907499	NPI:	1528312931
CHAIN CODE: (If applicable)		FEDERAL TAX ID: (If applicable)	455186271

Pharmacy Name: Healthy Pharmacy Solutions

Legal Name: Healthy Pharmacy Solutions, INC

Address: 8021 Research Forest Drive, City: The Woodlands State: Tx Zip: 77382

Phone Number: 8325850240 Is this a landline? [X] Yes [ ] No

Fax Number: 8325850244

County: HARRIS How long has pharmacy been at this address? 2 Years, 3 Months

Name of Current Owner: Sheryl Symonette Contact Person: Sheryl Symonette

Name of Other Individual Authorized to Sign on Owner's Behalf:

Mailing Address (If different from Physical Address above)

Address: City: State: Zip:

Remittance Address (If different from Mailing Address above)

Name to be printed on check: Healthy Pharmacy Solutions

Address: City: State: Zip:

List names and license #s of all Pharmacists employed (attach separate sheet if necessary):

Pharmacist/Prescriber in Charge:	Sheryl Symonette	License #	26988
Pharmacist Name:		License #	
Pharmacist Name:		License #	
Pharm Tech:		License #	
Pharm Tech:		License #	

GOVERNMENT EXHIBIT 218 4:18-CR-368

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TYPE OF PRACTICE: Indicate the anticipated percentage of Rx volume in each setting

☒	Open Door Retail/Community	100.00 %			☒	Medicaid	2.00 %
☐	Closed Door/ Clinic Facility	%			☒	Medicare	35.00 %
☐	Mail Order	%	☐ Local	☐ Out of State	☐	Workers Comp	%
☐	Nursing Home/LTC	%			☐	340B	%
☐	Internet Pharmacy	%	☐ New	☐ Refills %	☒	Compounds	25.00 %
☐	Home Infusion	%			☐	Dispensing Physician	%
☐	Self Administered Injectable/Specialty	%					
☐	Other	%	List Other:				

BUSINESS INFORMATION:

Federal DEA #: FH3579589 State Tax ID: 32047804144 State: TX

Medicaid #: 146674 State: TX Insurance Carrier: Pharmacists Mutual

(If more than one state attach list)

Software Vendor: Pioneer Switch Company: Emedon

Email address: info@healthypharmacysolutions.com Pharmacy Website URL: www.healthypharmacysolutions.com

Hours of Operation:

M-F 09:00 AM 06:00 PM Sat: AM PM Sun: AM PM

☐ Open 24 hrs Holidays: AM PM

☒ E-Prescribing/Vendor: SureScript ☐ Braille Labeling ☐ Emergency Services ☐ Handicap Access

☐ Drive-Through ☐ TTY (Hearing Impaired) ☒ Delivery Service/Mileage 10 ☐ Out of State

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	QUESTIONNAIRE SECTION	YES	NO
1	Is this pharmacy an open-door pharmacy that fills prescriptions for all walk-in customers without restrictions? *If no, please provide detailed explanation of pharmacy restrictions.*	☒	☐
2	Do you maintain electronic patient profiles?	☒	☐
3	Do you review prescriptions dispensed for drug interactions?	☒	☐
4	Are you currently affiliated with a buying group or co-op other than a PSAO (e.g., GPO)? *If yes, please provide the name(s) of affiliated buying group(s).*	☐	☒
5	Has the pharmacy (or another pharmacy you have owned) been disciplined by a State Board of Pharmacy, government entity or any other regulatory authority (i.e. State or Federal DEA or State Medicaid Department)? *If yes, please attach explanation of action taken, board order letter, and any other supporting documents from the State Board of Pharmacy, government entity, or other regulatory authority.*	☐	☒
6	Have any of the pharmacists, pharmacy technicians, owner or employee(s) of the pharmacy been disciplined by the State Board of Pharmacy, a government entity, or any other regulatory authority (i.e. State or Federal DEA or State Medicaid Department) in the last 10 years? *If yes, please attach details and letter(s) of disciplinary action.*	☐	☒
7	Presently, or at any time in the last 10 years, has the pharmacy, its owner(s)/principal(s) or any of its pharmacists been the subject of a civil lawsuit or criminal prosecution involving fraud, deceit, deception or a similar offense involving moral turpitude? *If yes, please attach detailed explanation.*	☐	☒
8	In the last 10 years, has the pharmacy or any of its owners/principals filed for bankruptcy, reorganization, or made a general assignment in favor of creditors? *If yes, please attach detailed explanation.*	☐	☒
9	Presently, or at any time in the last 10 years, has the pharmacy, its owner(s)/principal(s), its pharmacists, or any of its employees been suspended or excluded by the Office of Inspector General (OIG) from participating in any federal or state health care program (e.g., Medicare, Medicaid, TRICARE) or by the General Services Administration (GSA) from participating in any government contract/services? *If yes, please attach detailed explanation including applicable dates.*	☐	☒
10	Have any of the owner(s), member(s)/principals(s), officers, or directors of the Pharmacy owned any other Pharmacy(ies)? *If yes, please attach a list of the pharmacies, their NCPDP number(s), and the names of the owners, entity member(s)/principal(s), officers and directors.*	☐	☒
11	Has the pharmacy ever changed names? *If yes, please attach a list of the previous name(s), NCPDP number(s) if different, and the date(s) the name changed.*	☐	☒

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12	Has the pharmacy ever undergone a change in ownership? *If yes, please provide a list of the previous owner's name(s), ownership dates, and NCPDP number(s) if different.*	☐	☒
13	In the past three (3) years, has any vendor providing services, supplies or medications to this Pharmacy, been excluded from participation in Federal or state health care program or government contract, or been otherwise subject to any restriction by the OIG or other state or government agency? *If yes, please attach detailed explanation including applicable dates.*	☐	☒
14	Has the pharmacy obtained any accreditations/certifications (e.g., PCAB, ACHC, The Joint Commission, URAC, VIPPS, etc.)? *If so, please submit a copy of certification(s).*	☐	☒
15	Does the owner/pharmacist-in-charge currently hold any non-resident state licensure(s)? *If yes, please submit a copy of license(s).*	☐	☒
16	Does the pharmacy provide sterile compounding medications? *If yes please provide most current certification document* (e.g., PCAB, air flow hood/HEPA filtration, etc.).	☐	☒
17	Do you or your pharmacy(ies) deliver prescriptions to out-of-state customers? *If Yes, identify states where you plan to service customers and provide corresponding out-of-state pharmacy licenses:*	☐	☒
18	Do you or your pharmacy(ies) contract with or employ a sales force? *If Yes, please describe the activities of the sales force:*	☐	☒
19	Do you or your pharmacy(ies) provide compound product samples to prescribers or members? *If Yes, please describe when/how samples are provided:*	☐	☒
20	Do you or your pharmacy(ies) provide compounding services for or through any other entities (i.e. providing compounds services through other pharmacies or directly to prescribers for dispensing)?	☐	☒
21	Do you or your pharmacy(ies) compound investigational/Non-FDA approved compounds (i.e. Domperidone, Estriol, and Cetyl Mesyrlioate Oil)? *If Yes, please provide all Investigational New Drug Applications (INDs)*	☐	☒
22	Do you or your pharmacy(ies) ever waive or offer a reduction of member copayments? *If Yes, please provide a copy of your written policy relating to the waiver/reduction of copayments.*	☐	☒
23	Do you or your pharmacy(ies) use or provide pre-printed prescription forms for any of your compound preparations? *If Yes, please provide examples of any prescription forms*	☐	☒
24	Does any person with prescriptive authority have a direct or indirect financial interest in the pharmacy(ies)? For the purposes of this question, a "financial interest" includes, but is not limited to, any direct ownership, ownership by an immediate family member (spouse, child, etc.), paid consulting relationship, waged or salaried employment relationship? *If Yes, identify the individual and describe his or her financial interest:*	☐	☒
25	Identify the names of all primary and secondary wholesalers/suppliers that service your pharmacy(ies). Provide a copy of the most recent invoices from each wholesaler/supplier Independent Pharmacy Cooperative, HD Smith, Anda, Freedom		

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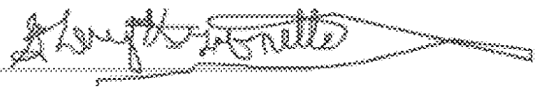
26	**Do you have a policy in place for setting your usual and customary price?** ***If Yes, please provide a copy***	☐	☒
27	**Do you have a central fill or shared services arrangement with any other pharmacy or facility?** ***If Yes, please provide the corresponding licenses and identify all pharmacies/facilities with which you have such a relationship:***	☐	☒

Indicate all languages other than English spoken by staff within this pharmacy and languages in which prescription drug labels can be provided:

Lang	Label		Lang	Label		Lang	Label		Lang	Label	
☐	☐	Arabic	☐	☐	Armenian	☐	☐	Cambodian	☐	☐	Chinese
☐	☐	Farsi	☐	☐	French	☐	☐	Hindi	☐	☐	Indian
☐	☐	Japanese	☐	☐	Korean	☐	☐	Mandarin Chinese	☐	☐	Russian
☒	☐	Spanish	☐	☐	Tagalog	☐	☐	Vietnamese	☐	☐	
☐	☐	Other									

- I certify that each answer on this Provider Certification (including attachments) is true and correct.
- I agree to notify Express Scripts immediately in writing in the event of a change in the information provided which would make any part of this Provider Application untrue or inaccurate. I understand that failure to do so will be considered a breach of my Provider Agreement and could result in disciplinary action including, but not limited to, immediate termination of my Provider Agreement.
- I give Express Scripts, and its designee(s), if any, permission to contact any individual, company, organization, etc, including state and federal licensing agencies, as may be necessary to verify the information submitted herein and to ask questions about disciplinary action, the pharmacy's license, or any pharmacist licensed, employed by or dispensing prescriptions at the pharmacy.

Printed Name: Sheryl A Symonette

Signature: 

Title: Authorized Signatory

Date: 02/18/2015

EXPRESS SCRIPTS®

PHARMACY DISCLOSURE FORM

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require you to fill out this form if you are enrolling, re-credentialing, re-contracting your Pharmacy or Pharmacy chain, or if there have been significant changes to the information required on this form (e.g. a change in ownership). [Note: Each pharmacy participating in Group Purchasing Organization (GPO) or Pharmacy Services Administration Organization (PSAO) MUST fill out its own form.] If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Please retain a copy for your files and return the original with the application.

Please answer all questions as of the current date. If a question is not applicable please respond **N/A** for that question.

NO QUESTIONS SHOULD BE LEFT BLANK.

I. Identifying Information

Name of person completing form	Phone number of person completing form
Sheryl Symonette	8325850240

Name of Pharmacy or Pharmacy Chain:

Healthy Pharmacy Solutions

DBA Name:

Healthy Pharmacy Solutions, INC

Address(es): If you are a small chain (10 or fewer stores) list each location. If you are a large chain, provide your corporate address.

Street Address	City	State	Zip
8021 Research Forest Dr, Ste D	The Woodlands	Tx	77382

Federal Tax Identification Number:	Pharmacy NCPDP # (If you are a small chain (10 or fewer stores) list each NCPDP. If a large chain, provide your chain code)	Pharmacy NPI # (If you are a small chain (10 or fewer stores) list each NPI. If a large chain, provide your chain code)
455186271	5907499	1528312931

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PHARMACY DISCLOSURE FORM

II. Information Regarding Ownership, Control, and Management

(a) **Ownership/Control:** Provide the information requested below individual or entity having an **ownership interest of 5% or greater** or **control** interest in this Pharmacy or Pharmacy Chain. Ownership and control may be "direct" (an individual who owns the pharmacy) or "indirect" (an individual who owns 5% of the company that owns the actual pharmacy or pharmacy chain). For corporate entities, please include, as applicable, any primary business address, every business location and any P.O. Box on a separate sheet.

Name of individual or entity	DOB	Address	SSN/TIN	% Owner-ship	Title
Sheryl Symonette	[redacted]			50.00	Co-owner treasurer
Mary Mckinney				50.00	co-owner /President

(b) **Management/Agency Relationship:** List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for the Pharmacy or Pharmacy chains **Managing Employees, Pharmacists in Charge** and **Agents**.

Name	DOB	Address	SSN	Title
Sheryl Symonette	[redacted]			Pharmacist in Charge

(c) **Ownership of Subcontractors:** Provide the name, address and TIN for any subcontractor that the Pharmacy or Pharmacy chain has an ownership interest of 5% or greater.

Name of Subcontractor	Address	TIN

III. Relationship of the Parties

Are any of the individuals listed in **Section II (a) and/or (b)** related to each other? ☐ Yes ☒ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Are any of the individuals listed in **Section II (a)** related to someone with a controlling or ownership interested of 5% or more in any subcontractor(s) providing services to the Pharmacy or Pharmacy Chain? A subcontractor is company that performs business functions related to the provision of pharmacy services, i.e. billing agent. ☐ Yes ☒ No

If yes, provide detail below:

Name	Name of Subcontractor	TIN	Name of Related Individual	Relationship

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PHARMACY DISCLOSURE FORM

IV. Related Healthcare Entities and Subcontractors

Does the Pharmacy, Pharmacy Chain, or any of the individuals or entities listed in **Section II (a)** have a controlling or ownership interested of 5% or more in any other health care providers or subcontractors? ☐ Yes ☒ No

If yes, provide the following information about the subcontractor:

Name	TIN	Address	% Owner -ship	Name of person/entity with control/ownership

V. Convictions, Debarment, Exclusions, and Terminations[1]

Have any of the individuals or entities listed in **Section II (a) or (b)** ever been **"convicted"**[2] of a crime related to fraud or to any program under Medicaid, Medicare, CHIP, TRICARE, or Title XX program? ☐ Yes ☒ No

If yes, provide detail below:

Name	Date	Type of Conviction

Have any of the individuals or entities listed in **Section II (a) or (b)** ever been **"debarred"**[3] or otherwise excluded from participation in Federal Government Contracts including under the provisions of Executive Order 12549? ☐ Yes ☒ No

If yes, provide detail below:

Name	Length of Debarment	Reason for Debarment

Have any of the individuals or entities listed in **Section II (a) or (b)** ever been "**Suspended**,"[4] "**Excluded**"[5] or "**Terminated**"[6] from participation in Federal Programs, including Medicare, Medicaid, CHIP or TRICARE or under the provisions of Executive Order 12549 ? ☐ Yes ☒ No

If yes, provide detail below:

Name	Date	Reason for Exclusion of Termination

Has any person or entity on the listed in **Section II (a) or (b)** ever had **Civil Monetary Penalties** (CMPs) assessed against them? A CMP is a fine assessed against by a governmental agency that manages a federal pharmacy program.

Yes ☐ No ☒

If yes, provide detail below:

Name	Reason for CMP	Amount	Date

Has any person or entity on the listed in **Section II (a) or (b)** ever been subject any other disciplinary or legal action relating to his/her participation in a state or federal health-care program? Yes ☐ No ☒

If yes, provide detail below:

Name	Type of Action	Date

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[1] In answering these questions, please refer to state licensing board information as well as the Federal Debarment List located at: www.sam.gov or for a listing of federally debarred and suspended individuals/entities and the Federal List of Excluded Individuals/ Entities (LEIE) database, available at: http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

2 "Convicted" means a judgment, conviction, finding of guilt, or entry of a guilty or nolo contendere plea in any Federal, State or local court regardless of pending post-trial motions, pending appeals or whether the conviction was expunged. "Convicted" also includes individuals or entities participating in a first offender or deferred adjudication program where conviction has been withheld. 42 CFR 1001.2

[3] "Debarred" means an individual is not allowed to participate in contracts paid for by the Federal Government, whether or not those contracts are in the pharmacy or healthcare area.

[4] "Suspended" means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court were not reimbursed under Medicaid.

[5] "Excluded" means that a person or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS, OIG) that they may no longer work with any federally funded health care program.

[6] "Terminated" means the person or entity lost the right to bill a State's Medicaid or CHIP program for a cause related to fraud or abuse.

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PHARMACY DISCLOSURE FORM

VI. Significant Business Transactions

In the past 12 months, has the Pharmacy or Pharmacy Chain had any financial transaction with any subcontractors totaling more than $25,000? (42 CFR 455.105). ☐ Yes ☒ No

If yes, list the ownership of the subcontractor with whom this provider **has had business transactions totaling more than $25,000** during the previous twelve month period.

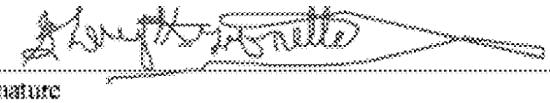
Name Subcontractor	Address	Owner(s)

Has the Pharmacy or Pharmacy Chain had any significant business transactions with any subcontractor or wholly owned suppliers over the previous five years? (42 CFR 455.105). ☐ Yes ☒ No

If yes, please provide details below:

Name Supplier/Subcontractor	Address	Transaction Amount

I certify that the information provided herein, is true and accurate. Additions or other changes to the information must be submitted immediately upon revision I understand that misleading, inaccurate, or incomplete data may result in a denial of participation. I further understand that this Disclosure Form constitutes part of the Provider Agreement with Express Scripts and that failing to provide full and accurate information, including providing immediate notice of any change relating to this information, will constitute a breach of the Provider Agreement. I certify that the Pharmacy or Pharmacy Chain will comply with legal requirements, including but not limited to, the requirements of 45 CFR Part 76.



Signature

Authorized Signatory

Title (or indicate if authorized Agent)

Sheryl A Symonette

Name (please print)

02/18/2015

Date